

League tables lead to funding loss

Jackie Cresswell, *London*

The latest league tables for university medical research will result in some British establishments not receiving central government funding next year.

The higher education funding councils carry out a research assessment exercise every four years to assess the quality of research across all subject areas in different education establishments in Britain. The assessment also determines who should receive funding. This is only the second time the exercise has been carried out and the councils say that overall there has been an improvement in the quality of the research.

Medical research is divided into clinical laboratory sciences, community based clinical subjects, hospital based clinical subjects, and preclinical studies. Establishments are given grades on a scale with grades 1, 2, 3a, 3b, 4, 5, and 5*, with 5* being the highest accolade.

All universities who received a rating of 1 will definitely be ruled out of funding in the next financial year, 1997-8. These include Bournemouth University in clinical laboratory sciences, De Mont-

fort University and University of Westminster in community based clinical subjects, and St Martin's College in preclinical studies.

The Higher Education Funding Council for England will decide on 21 January whether the establishments that received a grade 2 will also not receive funding in the next financial year. Such a decision would hit some of the more well known names in medical research who were graded 2 for clinical laboratory sciences—for example, St George's Hospital Medical School; King's College, London, for immune regulation in a joint submission with Roehampton Institute; and Queen Mary and Westfield College. All the universities assessed were rated well on hospital based clinical studies, with 3a being the lowest grade.

The assessment exercise is based on peer review by panels of experts and includes examining details of published research and information about the numbers of research students and research income during the assessment period. The departments also have to give a statement of their research achievements, how they



JOHN COLES/IMPACT

The quality of research has improved overall

support and promote research, and any indicators of external recognition.

Professor Brian Fender of the Higher Education Funding Council for England underlined its commitment to the funding policy: "The policy of selectivity has encouraged institutions to manage their research effectively. They have focused their effort and resources on areas of strength. Our policy is to reward excellence. We shall ensure that most funds are channelled to the best departments, wherever they exist." In the financial year 1996-7 the funding council for England distributed £638m (\$957) for research in English universities and colleges.

Peter Garland, chief executive of the Cancer Research Institute, which received a 5* rating, believes that the system is fair. He said: "The system rewards excellence, and it does make sense to concentrate limited resources where there is excellence." He pointed out that departments can and do move up and down the leagues and that some of the ratings depend on the support and emphasis placed on research by the university.

Mr Garland added: "Each university decides where its

funds should be concentrated, and it may be that some of the lower rated research departments should or will concentrate more on the teaching side."

But Professor Robert Boyd, principal of St George's Hospital Medical School, which was given a grade 4 for preclinical studies, but only a grade 2 in clinical laboratory services said it was important to look at the whole picture and not just concentrate on the grade given: "Schools may have appeared to do less well but close attention to detail shows they have done much better."

Bournemouth University which was only graded 1 for clinical laboratory services but did well in other areas feels tradition is still too much of a factor. A spokesman said: "The university is very much of the opinion that the assessment bodies are still far too preoccupied with the "blue skies" (more ethereal) research conducted at many of the traditional universities, rather than the applied research carried out at institutions such as Bournemouth."

1996 Research Assessment Exercise: The Outcome is available from the Higher Education Funding Council for England, price £15.00.

Highest ratings in each section

Clinical Laboratory Sciences

Institute of Cancer Research (Biological Clinical Laboratory Sciences)	5*
University of Oxford—Dunn School of Pathology	5*
Royal Postgraduate Medical School	5*

Community Based Clinical Subjects

University of Cambridge	5*
King's College—Institute of Psychiatry	5*
University of Oxford	5*

Hospital Based Clinical Subjects

Imperial College—National Heart and Lung Institute	5*
University of Oxford	5*
University College London—Institute of Ophthalmology	5*

Pre-clinical Studies

Imperial College of Science, Technology and Medicine	5
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Doctors penalised for prescribing cannabis

Fred B Charatan, *Florida*

Doctors who prescribe marijuana for seriously ill patients in Arizona and California face the prospect of losing their licence to practise.

The move follows the recent passing of state laws that allow doctors to prescribe cannabis for treating conditions such as cancer, AIDS, chronic pain, spasticity, glaucoma, and migraine (16 November, p 1224).

Under a plan approved by President Bill Clinton letters will be sent to every doctor in the two states warning that marijuana remains an illegal narcotic under federal laws and threatening that their power to dispense drugs will be revoked if they recommend or prescribe it.

The president's drug chief, General Barry McCaffrey, said: "Essentially, we reaffirm the primacy of federal law," and he warned that doctors who prescribed illegal drugs would be prosecuted or removed from the federal registry that allows them to write prescriptions.

The American Medical Association supports the administration's position. Although it urges further research on the validity of marijuana as an effective medical treatment, it said: "Right now the California and Arizona initiatives are in direct conflict with federal law."

Dr David Lewis, director of the Center for Alcohol and Addiction Studies, Brown University, Providence, Rhode Island, said of the administration: "They can't go after the voters in California and Arizona, so they go after the medical profession. Now, the federal government is entering the practice of medicine, placing itself in the physician's office between the doctor and patient."

The American Civil Liberties Union said that the Clinton administration's uncompromising opposition to legalising marijuana for medicinal purposes is out of step not only with the voters of Arizona and California but with public opinion nationwide. □



Breast surgery is sometimes viewed as superficial surgery

"Drive by" mastectomies to be banned

Deborah Josefson, *Connecticut*

Legislation is being drafted in New York to outlaw outpatient mastectomies on both a state and federal level.

The proposal will force health maintenance organisations and other insurers to pay for at least 48 hours of inpatient care after a mastectomy and is expected to have widespread bipartisan support. Currently, "drive by" mastectomies are legal, allowing patients to be discharged from the hospital within

24 hours of surgery.

The bill also proposes that insurers pay for breast reconstruction after a mastectomy because mastectomy is a disfigurement. Currently, breast reconstructive surgery is considered akin to elective cosmetic surgery and is not covered by insurance. The proposal follows the recommendations of a Women's Advisory Council health commission convened by New York governor George Pataki.

Dr Michael Moore, a breast surgeon at New York's Columbia Presbyterian Medical Center, supports the proposal. "Breast surgery is sometimes viewed as superficial surgery because it doesn't violate a body cavity. But

in fact it is both very painful and an exceedingly difficult emotional time for the patients. Patients often require massive amounts of post-surgical analgesia, with subcutaneous morphine injections. They also need to be educated about managing their drains. For these reasons alone, 24 hours isn't enough."

Assemblyman Richard Godfried, chairman of the New York State Health Committee and a cosponsor of the bill, believes that the current legislation is suboptimal and that the entire system needs to be reformed. "Currently, we are responding on a case by case, diagnosis by diagnosis basis—and the media are setting the agenda. Last year it was babies, this year mastectomies."

He states that the situation could be rectified if other legislation which he has proposed to curtail abuses in managed care were passed—one is an independent appeal mechanism for denials of coverage of managed care, and the other would hold payers legally liable for detrimental consequences of denied coverage. Currently, patients denied insurance coverage can appeal against the decision, but the insurance company serves as the arbiter of the appeal and is therefore both judge and jury. Last year, these bills passed the assembly but not the state senate. □

Second Australian dies under euthanasia act

Christopher Zinn, *Sydney*

A second person has taken advantage of the world's first voluntary euthanasia legislation.

Mrs Janet Mills, aged 52, who suffered from the rare skin cancer mycosis fungoides, died from a lethal injection delivered by a machine in Darwin on 2 January under the Rights of the Terminally Ill Act, which became law in Australia's Northern Territory in July 1996. Mrs Mills used the so called death machine developed by a GP, Dr Philip Nitschke, who was with her when she died. The first patient, Bob Dent, died in September 1996 (*BMJ* 1996;313:835).

The Australian Medical Association, which has always opposed the legislation, said that the opinion among doctors had swung against the law. "Taking somebody who is conscious,

alert, not depressed but who wants to die because they have a terminal illness and actually delivering a lethal injection is just too far for most doctors to contemplate," said the association's president, Dr Keith Wollard.

Mrs Mills, who moved to Darwin from her home in South Australia to take advantage of the act, last month appealed through the media for help to get the final signature needed to end her life. She had the two required signatures of a GP and a psychiatrist but needed a Northern Territory resident specialist to confirm her diagnosis and prognosis. It came at the end of December.

The federal MP Kevin Andrew, whose private member's bill threatens to overturn the state legislation, said that the

second death increased the chances of his bill succeeding. The bill was passed overwhelmingly in the lower house in December, and it is due to be debated in the senate in the next few months. "I suspect another death or even more deaths will simply make the issue more real," Mr Andrew said.

The Northern Territory's government said just before Mrs Mills's death that it would consider changing the legislation to make it easier for patients to use. The chief minister, Shane Stone, said that he would not rule out allowing non-Northern Territory resident specialists to give the key third signature because of the small number of such specialists in the state. The regulation was an unexpected one introduced just before the bill became law. □

France faces first tobacco lawsuits

Alexander Dorozynski, *Paris*

The French national tobacco manufacturer and distributor, Société Nationale d'Exploitation Industrielle des Tabacs et Allumettes (SEITA), is being sued for the first time by people who believe that their cancers were caused by smoking.

The plaintiffs are the relatives of a woman who died of lung cancer at 35 and of a 48 year old man with multiple cancer. Both had smoked unfiltered Gauloises cigarettes heavily since their teens. The woman stopped smoking when her cancer was

diagnosed in 1995; she received intensive radiotherapy and chemotherapy but died in October 1996. Her family is asking for Fr1m (£112 000; \$168 000) in damages. The man suffering from multiple cancer is still alive; his wife is seeking damages of over Fr2.7m.

The lawsuits are sponsored by France's national committee against smoking, which wants a test case. The lawyer for both plaintiffs, Francis Caballero, says that French law clearly holds the manufacturer of a dangerous

product responsible for it even if the product is no longer under the manufacturer's control. He also maintains that SEITA failed to give smokers sufficient warning about the dangers of smoking and indulged in excessive advertising for Gauloises, France's popular, dark tobacco, unfiltered cigarette. In a country where the protobacco culture is still strong the outcome of the trials is uncertain.

In 1976 legislation required that the warning "Abus dangereux" (Abuse is dangerous) should be printed on cigarette packages, and in 1991 the compulsory warning was changed to "Nuit gravement à la santé" (Gravely harmful to health).

Tobacco advertising was banned, and in 1992 legislation was introduced to restrict smoking in many public places and create non-smoking areas in restaurants and cafes. The law has been largely ignored and only exceptionally enforced. Several price increases (the last one in December) doubled the price of cigarettes in three years, bringing the price of a packet of Marlboro, the most popular brand, to Fr19.30. But these measures hardly made a dent in the French protobacco culture: smoking has decreased slightly in five years, but about 40% of men, 30% of women, and 40% of young people of both sexes are smokers. □

Chinese clamp down on blood products

Richard Tomlinson, *Beijing*

The Chinese government last week issued strict new regulations governing the production and distribution of blood products after scares about contamination with HIV.

The new law took effect on 5 January and is intended to improve the collection of blood and the production of blood products after a scandal last year in which samples of serum albumin, manufactured by a military run factory in Guangdong province, were found to be contaminated with HIV.

The official Xinhua news agency said that there would be harsh punishments for anyone who violated the new law, which was signed into effect by the prime minister, Li Peng. However, no details were published about the 5000 word new ruling and the new "controlling measures" for firms that produce and manage blood products.

The Chinese authorities have already tried to impose far more extensive screening of blood, but outside the big cities this is not yet a reality. Last year's case, which concerned the Wolongsong brand of blood albumin, highlighted some of the shortcomings of China's blood banks and blood product manufacturing lines. The product was banned last April, but it was not until six months later that the Chinese foreign ministry publicly confirmed that

tested samples were contaminated with HIV.

About 60% of China's clinical blood supply comes from paid donors, among whom there is a much higher risk of infections such as with HIV and hepatitis viruses. A health ministry survey put the rate of hepatitis C among a sample of people who regularly sold their blood at more than 40%. Among non-paid blood donors the rate was about 1%.

As in other developing countries, those who are poor and desperate enough to repeatedly sell their blood are often also those most at risk of infection, including drug misusers, prostitutes, and destitute migrant workers. Many blood collection centres are run illegally by middlemen, who make no effort to sterilise equipment and routinely reuse needles.

More than 5100 people were officially registered as HIV positive in China at the end of last October, but experts say that the true number of carriers is probably nearer 100 000.

Criminals have also realised the value of blood, and so called vampire gangs have been reported in the Chinese media for kidnapping people and then taking their blood repeatedly over a number of days. Last autumn, the Red Cross Society of China launched a campaign to urge people to donate blood for free. □



Sunlight can be a practical way to purify water

Sunshine can purify water

Alison Boulton, *London*

Keeping drinking water in plastic bottles in direct sunlight can significantly reduce morbidity from diarrhoea, says a recent Kenyan study. Diarrhoea currently kills 4-6 million children in the developing world—12 000 a day.

Researchers studied 206 Maasai children aged 5-16 years old whose drinking water was contaminated with faecal coliform bacteria (*Lancet* 1996;348:1695-7). In the controlled field trial 108 children placed two 1.5 litre bottles containing contaminated drinking water on the roof of their hut at dawn, leaving them in the full sun until midday, and 98 other children placed their bottles indoors in the shade. The occurrence and severity of diarrhoea over a period of 12 weeks was

recorded by questioning the mother.

In the solar group diarrhoea was reported in 439 of the two week reporting periods during the 12 week trial (average 4.1 episodes per child). In the control group diarrhoea was reported during 444 reporting periods (average 4.5 per child). Diarrhoea severe enough to impede tasks occurred during 186 reporting periods in the solar group and 222 periods in the control group. The average number of severe episodes was 1.7 in the solar group compared to 2.3 in the control group—a reduction of a third.

Study author Mr Ronan Conroy said: "Our data showed that by harnessing solar energy together with bottles which would otherwise be domestic refuse, a realistic and effective water purifying system can be provided for people with few or no resources." □

Dutch plan to tackle waiting lists

Tony Sheldon, *Utrecht*

The Dutch health ministry has announced radical plans to tackle chronic problems of long hospital waiting times, especially for eye, heart, and orthopaedic surgery. The move is prompted by new research from the healthcare inspectorate showing that in the first half of 1996 up to 100 patients benefited from schemes offering faster treatment for non-medical reasons.

Health minister Professor Els Borst-Eilers has denounced these largely employee based schemes as unfair. Private company schemes offering employ-

ees faster treatment were, she argued, contrary to the first article of the Dutch constitution, which guarantees equality to all citizens.

Professor Borst's plans include a special fund of 50m guilders (£18m; \$27m) to tackle "unacceptably long" waiting times in 1997. But she has emphasised that the problems will not be solved simply by throwing money at them. Hospitals applying for waiting list money must also be prepared to take "structural measures." These include setting up a

national waiting times register based on uniform diagnoses. An independent team or "waiting list brigade" will be set up to investigate persistent local problems.

More flexible working hours, promoting evening and Saturday shifts, are to be encouraged, and regional waiting times registers are proposed to encourage hospitals, consultants, and health insurers to transfer patients for quicker treatment. Waiting list information points are also proposed for regional patient groups.

Rob van der Plank, health adviser to the employers' organisation, welcomed the government proposals as waiting lists cost Dutch employers an esti-

mated 400m guilders a year in sickness pay, but he defended schemes to buy employees faster treatment, arguing that these meant more money for hospitals and so benefited everyone.

There is widespread dissatisfaction with waiting times. Research by the central statistics office has found that 90% of the 450 000 Dutch patients awaiting specialist hospital treatment each year thought that they had to wait too long. Roughly 117 000 patients wait an average of 66.5 days for orthopaedic surgery and 48 000 patients nearly 90 days for eye surgery. The foundation for orthopaedic patients claims that there is an average six month wait for hip operations. □

Stable HIV rates hide worrying trends

Hilary Bower, *London*

Data from the third unlinked anonymous survey of HIV infection in England and Wales show static or declining prevalence in most groups.

At 1.5%, infection rates among injecting drug misusers in London in 1995 were half those in 1994, while the prevalence in homosexual and bisexual men has declined slightly over the past five years, averaging 10% in London and 2.5% across the rest of Britain. Among heterosexuals attending genitourinary clinics the prevalence of HIV infection remains low—just over 0.6% in the London area and 0.1% in other regions. Higher prevalence in the London area is thought to result mainly from the higher concentration of people who have lived in or visited sub-Saharan Africa, where heterosexual transmission is common.

But experts say that the headline figures hide worrying trends. Dr Angus Nicholl, consultant epidemiologist with the Public Health Laboratory Service in London, says that stability simply means infection rates are keeping up with death rates. "We think the falling levels in injecting drug misusers are real. But we're pretty certain that the falling levels among gay men are not so true and are due to changing clinical management where those with a clinical diagnosis are now more likely to be

cared for in specialised clinics which are not part of the survey. When combined with information from diagnostic testing we know prevalence among gay men remains unchanged. Given that there is significant mortality, unchanging prevalence still means new infections are taking place."

He added: "Stability suggests that everything is under control and there is no need to sustain resources. That is not the case."

As yet unpublished data from the voluntary testing scheme suggest that 1996 will show the highest rate of newly diagnosed cases of HIV since 1985, the year in which HIV testing became available. Dr Nicholl said that the significant prevalence of infection in gay men under 25 showed that the safe sex message still needed to be intensively targeted.

The further area of concern is the low number of people who know that they are HIV positive. The survey found that the rate of clinically diagnosed HIV among gay men dropped by a quarter between 1993 and 1995 to 58%.

But the most "depressing" finding, Dr Nicholl said, is the continued low awareness of HIV state among pregnant women. Less than a fifth of pregnant women infected with HIV know their state. □



DAVID REED/IMPACT

The benefits of alternative therapy for the menopause are unknown

AMA cautions on alternative therapies

Charles-Gene McDaniel, *Chicago*

The American Medical Association has produced guidelines for doctors who counsel and treat women who are menopausal and says that it "cannot recommend the use of alternative therapies for the treatment of the symptoms of menopause."

The association's council on scientific affairs recommended action because of the growing number of unproved alternative treatments, several of which it has evaluated. It commented on the "explosion of self-help books on menopause" and said that the alternative health industry "has responded enthusiastically

to women's desire to experience 'natural menopause' through the use of natural methods such as vitamin supplements, herbal remedies, exercise, and change in diet as alternatives to hormonal treatment."

In its report the council said that its research found no scientific evidence to support the alternative therapies that it considered: vitamin supplements; dietary practices and exercise; homoeopathy; herbal medicine; and visualisation, hypnosis, and relaxation techniques.

But the council pointed out that it was important for doctors to inquire routinely about patients' use of alternative therapies and discuss them in a non-judgmental, non-punitive manner. It also pointed out that "an alternative therapy approach may compromise the effect of a prescribed treatment." □

Gulf war research given go ahead

The British government has finally decided to carry out a rigorous epidemiological investigation into the Gulf war syndrome, Susan Mayor examines the proposals.

The Ministry of Defence announced just before Christmas that a grant of £1.3m (\$1.95m) will fund two major projects, one investigating the epidemiology of symptoms occurring in veterans of the war and a second assessing possible effects on fertility and reproductive outcomes (box). Researchers met military staff to sort out the final details this week.

Since the conflict in 1990 there have been reports of a wide range of complaints in veterans, including headaches, fatigue, sleep disorders, and musculoskeletal complaints, as well as congenital malformations in their offspring. There have also been suggestions about the possible role of organophosphorus insecticides and the combination of vaccines that military staff were given.

"But this is all speculation," points out Simon Wessely, professor of epidemiological psychiatry at King's College School of Medicine, who is about to start a third research project into symptoms. "All we do know is that some of the 51 000 people who went to the Gulf war from the United Kingdom have since become sick—that is not disputed."

One of the research projects will examine whether there is really excess morbidity in Gulf war veterans. If so there are two possible explanations. Firstly the

observed illness may represent an increase in the rate of a condition that is already documented. Secondly, there may be an entirely new diagnostic entity, the Gulf war syndrome.

The most useful information currently available on the Gulf war syndrome comes from the medical assessment programme for veterans, which began in 1993 and has now examined over 900 patients. Head of this programme, Group Captain Bill Coker, is about to submit an analysis of the first 500 cases for publication. "A vast range of conditions have been diagnosed," he reports. "A lot of patients are polysymptomatic, with many having 15 to 20 symptoms involving three or four body systems. This is one of the factors that has made the issue so difficult to study."

Stress disorder

An appreciable number of the veterans have psychiatric symptoms, with many features of post-traumatic stress disorder. But other problems, including skin disorders, respiratory conditions, such as asthma and chronic bronchitis, and irritable bowel have also been found. The problem with these data is that they are from a self selected group of people who decided to seek medical help. The new research studies aim to assess



Vaccinations may have contributed to subsequent illness

the nature and extent of symptoms in a randomly selected sample of veterans compared with matched controls.

But the puzzle is particularly difficult to sort out because there are so many unknown factors. One of the recipients of the new Ministry of Defence research funding, Nicola Cherry, professor of epidemiology and occupational health at the University of Manchester, explains: "Epidemiological studies usually start with a group of people exposed to something and go on to assess the impact on health. Alternatively, they start with a group showing particular symptoms and work back to assess possible aetiology. In this case we have the group of people—those who went to the Gulf—but we don't yet know what is wrong with them or what, if anything, may have caused this."

A second hurdle facing the researchers is that the whole incident is shrouded in secrecy—necessary in war time but frus-

trating for those trying to track down veterans and work out what they may have been exposed to. The popular media have accused the government of a cover up, but the Ministry of Defence is obliged to keep secret the names and addresses of staff serving in the Gulf—it has never previously released such information to outside bodies. Following up Gulf veterans is also being hampered by poor record keeping during the war.

Confidentiality

Those about to embark on research, however, have been reassured that a decision has been taken at the highest level in the Ministry of Defence to provide the information that they require. All that remains is to work out the best way of maintaining as much privacy as possible for Gulf veterans. "The major thing is that all information will be kept on non-networked computers, so that no outside person can hack into them," explained Pat Doyle, senior lecturer in epidemiology at the London School of Hygiene and Tropical Medicine. All paper records will be kept in secure rooms, with access only to authorised staff. The research groups concerned have previous experience in handling sensitive information, having carried out studies in the nuclear industry, so consider themselves well prepared.

The new research seems to represent a positive move to lift the lid on the Gulf war syndrome. "The new studies will not give us all the answers but will at least tell us where we should be going. It is just a pity that they were not able to start sooner," concluded Professor Wessely. □

Research projects

The Ministry of Defence has provided £1.3m for two three year studies:

- Professor Nicola Cherry and her team at the University of Manchester's school of epidemiology and health sciences will investigate a sample of 6000 Gulf veterans to determine whether they are suffering more ill health than a control group of 3000 who did not serve in the Gulf, and, if so, the nature and magnitude of the risk. The study will assess whether there is a unique cluster of symptoms in veterans. A further study will investigate whether service in the Gulf war is associated with increased mortality or risk of cancer in the entire group of veterans

- Dr Pat Doyle and colleagues at the London School of Hygiene and Tropical Medicine will

investigate all Gulf veterans to see if they are experiencing adverse reproductive outcomes. The team will send questionnaires to all 51 000 veterans to gather data on infertility, miscarriages, and stillbirths. They will also investigate low birth weight and congenital abnormalities in veterans' offspring. Findings will be compared with a matched group of military staff who did not serve in the Gulf war. Because congenital abnormalities are likely to be rare, the study will require a high response rate. The study will investigate illness, including cancer, in veterans' children

- The United States Department of Defence has provided \$1m (£666 000) for Professor Simon Wessely and Professor Anthony David at King's College, London, to carry out a detailed epidemiological study into the pattern of illness in Gulf war veterans.

A surgeon becomes overseer of Scotland's health

Shortly after **Sir David Carter** became chief medical officer in Scotland there was an outbreak of *Escherichia coli* 0157 food poisoning. But he told Bryan Christie that was just one of the many challenges he faced in the new job



Sir David is prepared to speak out on controversial topics

When Sir David Carter took over as Scotland's chief medical officer he never imagined that he would be spending the days before Christmas inspecting conditions inside some of the country's abattoirs. These forays into unfamiliar territory were made necessary to gather information into Britain's worst outbreak of *Escherichia coli* 0157 food poisoning, which has killed 16 people and produced a total of more than 400 suspected cases. The outbreak in central Scotland struck only weeks after Sir David started his new job at the end of October 1996. It has reinforced the importance of the public health component of his responsibilities, although Sir David makes clear that this is only one of several challenges he faces.

He lists as his main priority the need to reshape hospital services in Scotland to ensure that high quality treatment is delivered in the most efficient man-

ner. That could entail closing down some existing services. "That is something that Scotland needs to come to terms with, although it's not Armageddon we're talking about," says Sir David. "Does Scotland need four renal transplant units, for example? Are accident and emergency

■ *"The public are worried about food safety in this country, and they are right to be worried."*

services organised in the most appropriate manner? I am just picking things out of the air—this is not a hit list." He is certain, however, that a debate needs to begin to determine if there are benefits to be gained from rationalisation and the adoption of alternative treatment options such as nurse led minor injuries clinics to take over some of the work of accident and emergency departments.

The model he wants to pur-

sue is the one already adopted for cancer services, based on specialist centres being supported by locally based cancer units. Over the next two years he hopes to reach agreement on the required structure and to define the protocols that staff should work to. "Finally, some years down the track you will hopefully see the dividends in terms of its effects on long term outcomes. I see that as a challenging agenda."

Sir David's decision at the age of 56 to swop life as a practising surgeon to become part of the government's health team has raised hopes within the medical community that greater attention will be paid to its views. Sir David is intensely aware of the pressures on today's health service. He has occupied chairs of surgery at both Glasgow and Edinburgh Universities, he is the current president of the Association of Surgeons, and he was due to take over as president of the BMA before his career change forced him to stand down. He is a man used to speaking his mind—a characteristic that he does not intend to abandon.

Doctors have worried that the role of the chief medical officer has been downgraded as the influence of the management executive has increased. Some senior doctors hope that Sir David is the man to redress that balance. He accepted the job on secondment, which theoretically means that he can leave at any time and return to the operating theatre. This might suggest someone who is not sure how things will turn out and has prepared a bolt hole in advance, but he dismissed such an idea. He accepts that the post has changed in recent years but says that a shared agenda was being

pursued by his office and the management executive. His team had a central role to play in shaping and influencing policy. "I would be astonished if there was not some dynamic tension from time to time, but I would hate to give the impression that I am beleaguered in any way. As a surgeon I was dealing with the end stage of health problems. What is exciting about this job is being able to influence the upstream end of events."

Sir David is prepared to speak out publicly on politically controversial topics such as health care rationing. He says that there is a need for a much more open debate on how finite resources should be spent. "It is inevitable if you want to start purchasing a particular new treatment or the latest form of major surgery that you have got to try to define where that fits."

Although he supports moves to condense medical training and to reduce junior doctors' hours, he is concerned that in certain specialist areas, such as surgery, insufficient time will be available to give the required training. He suggests that additional training may be needed, along the lines of the fellowship system in the United States, after conventional training is completed.

Sir David defends the extra resources devoted to health in Scotland (£850 (\$1275) a head in 1997-8 compared with £694 in England) and says that it is more in line with what a civilised country should be spending. Scotland has a different style of health service and that difference should be preserved even if it means occasionally adopting different solutions to those pursued south of the border.

Any detailed consideration of these and other issues has had to be abandoned as Sir David's days have been filled with responding to the food poisoning outbreak. Although this outbreak has been caused by *E coli* 0157, Sir David says that there are other problems to be addressed, including salmonella infection and bovine spongiform encephalopathy in cattle. "The public are worried about food safety in this country, and they are right to be worried. It seems to me there is going to have to be action at a number of levels." That could include looking critically at processes on the farm, in abattoirs, and at all stages of food processing, storing, and handling, including how food is prepared in the home.

At the end of his four year term of office Sir David says that he will be happy to be judged on three main areas: Will Scotland, by then, have the best structure of hospital services? Will it be able to respond effectively to major public health threats? And will the workforce be as motivated and excited by the job as people like Sir David would wish them to be? □